COVID-19 MEDICAL CERTIFICATION A: DATE OF ONSET
(To Be Completed by a Medical Professional)

TEACHERS' RETIREMENT SYSTEM
OF THE CITY OF NEW YORK (TRS)
55 Water Street, New York, NY 10041
www.trsnyc.org • 1 (888) 8-NYC-TRS

- **Please complete this Medical Certification in support of an application for COVID-19 Accidental Death Benefits pursuant to Chapter 89 of the Laws of 2020. This Certification is to be submitted when a COVID-19 laboratory test result is unavailable. Please submit the completed Certification to TRS as follows:**
  - **By email to accidentaldeathbenefit@trs.nyc.ny.us**
  - **By e-fax at (212) 918-9253**
  - **By mail to TRS at 55 Water Street, New York, NY 10041. Please note that there may be some delay in processing mailed forms during the pandemic.**
- **If you require assistance, please call TRS at (212) 510-4028, which is a dedicated line we have established for inquiries related to the accidental death benefit.**

This certification is for the below deceased member of TRS.

Member's First Name | MI | Last Name | Member's Social Security Number (last 4 digits only)

			X X X – X X – ☐ ☐ ☐ ☐

PART A: Please complete the following.

1. *In my professional opinion, the member named above contracted COVID-19 on or before* _____. (MM/DD/YYYY)

2. *I first made this determination on the following date:* _____. *(Date may be before or after the death of the member.)* (MM/DD/YYYY)

3. Please briefly explain your basis for this opinion as to when the decedent contracted COVID-19:

_____

_____

_____

_____

_____

_____

PART B: Please complete the following and sign and date below.

Printed Name: _____ License Number: _____

Best Contact Information: _____

I certify that I am a _____ (physician, nurse practitioner, or physician's assistant) who is in good standing in _____ (state) or who is authorized to practice in New York State by Executive Order during the declared COVID-19 State of Emergency. I do hereby attest that the information included in this certification and reported to TRS is true, accurate, and complete to the best of my knowledge and I understand any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability.

Certifier's Signature: _____ Date: _____ (MM/DD/YYYY)

TRS reserves the right to request additional information including, but not limited to, relevant medical records and professional credentials.